Draft Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics

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Table of Contents

Introduction 2

Definitions 5

Structure of the criteria 7

Vision guiding certification 9

Program Requirement 1: STAFFING 10

Program Requirement 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES 15

Program Requirement 3: CARE COORDINATION 21

Program Requirement 4: SCOPE OF SERVICES 28

Program Requirement 5: QUALITY AND OTHER REPORTING 44

Program Requirement 6: ORGANIZATIONAL AUTHORITY, GOVERANCE AND ACCREDITATION 48

References 51

Appendix A: Certified Community Behavioral Health Clinics Quality Measures 53

Required Measures 53

Optional Measures 60

Introduction

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (hereinafter the "PAM Act" or "the statute") was signed into law. Among other things, the PAM Act requires the establishment of demonstration programs to improve community mental health services, to be funded as part of Medicaid (PAM Act, § 223). In preparation for the selection of up to eight States[1] to field demonstration programs, the Secretary of Health and Human Services (HHS) is required, no later than September 1, 2015, to publish criteria for community behavioral health clinics to be certified by States (PAM Act, § 223(a(1))). Within HHS, the Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency charged with preparation of criteria. The draft criteria in this document are one step towards developing final criteria. These draft criteria were developed based on an environmental scan of existing and germane regulations and voluntary accreditations, a review of State Medicaid Plans, regulations of Federally Qualified Health Centers and Medicaid Health Homes, and quality measures currently in use by states. Before a draft of the criteria was completed, input was sought from the public through comments from a National Listening Session held on November 12, 2014, consultation with Tribal leaders held on November 5, 2014, and additional written public comments received November 12 through November 27, 2014. Based upon public comments, the draft criteria were finalized and prepared for public feedback in early February 2015. The final criteria are to be announced not later than September 1, 2015. The behavioral health treatment clinics that participate in this demonstration program, after meeting the final criteria, will be known as Certified Community Behavioral Health Clinics (CCBHCs).

In addition to preparation of these criteria, work is underway to generate, by September 1, 2015, guidance for the development of State prospective payment systems (PPS) to be used as part of the demonstration program (PAM Act, § 223(b)). After these criteria and guidance for the PPS are finalized, application materials will be made available to States. No later than January 1, 2016, HHS will award planning grants to States for the purpose of developing proposals to participate in the demonstration project (PAM Act, § 223(c)), with up to eight States selected by September 1, 2017 (PAM Act, § 223(d)). Among other things, preference in the selection of demonstration programs will be given where participating CCBHCs: (1) provide the most complete scope of services pursuant to these criteria, (2) improve availability of, access to and participation in services described in these criteria, (3) improve availability of, access to and participation in assisted mental health treatment in

[1] The term "State" is defined in the statute (PAM Act § 233(e(4))) as having "the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

the State, or (4) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending (PAM Act, § 223(d(4))). No later than December 31, 2021, HHS will submit recommendations to Congress concerning whether the demonstration programs should be continued, expanded, modified or terminated (PAM Act, § 223(d(7(B))).

Section 223(a) of the PAM Act specifies basic standards that CCBHCs must meet. These standards fall into six areas: staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority. These draft criteria address each area in turn. There are multiple objectives in the development of these criteria. The goal is to establish criteria that are consistent with the statute and flexible enough to account for differences between States and, therefore, to be achievable by provider agencies and States. The criteria and questions that will guide certification are informed by existing laws, regulations and standards, to the extent these were helpful and potentially applicable to the CCBHCs. Sources that have informed and guided development of the criteria are numerous but the draft criteria are most strongly influenced by:

- Criteria and processes that guide Federally Qualified Health Centers (FQHCs) (Health Resources and Services Administration (2014)).
- Centers for Medicare & Medicaid Services (CMS) regulations governing Community Mental Health Centers (CMHCs) that voluntarily participate in Medicare (42 CFR Part 485).
- Accrediting organization criteria for behavioral health programs and services (i.e., the Joint Commission, CARF, COA, AAAHC).
- State laws and regulations for administrative and clinical activities of organizations that provide comprehensive care encompassing both mental health and substance use services, referred to herein as community behavioral health clinics (CBHCs).
- Behavioral health services included within State Medicaid Plans.
- Reporting standards for behavioral health and other health care service delivery and quality control/assurance requirements.

Thus, the criteria are constructed to be as consistent as possible with language with which States and provider agencies are experienced and that has been used with success with diverse populations nationally (e.g., FQHC criteria, CMS regulations, accrediting agency standards). The criteria are designed to encourage States and CCBHCs to develop further their abilities to offer behavioral health services that comport with current best practices. The criteria also are designed to require providers

and entities that have arrangements with CCBHCs to provide services the CCBHC cannot provide, also to satisfy the requirements of certification, when considered with the CCBHC as one entity.

The development of the criteria in this document, governing State certification of the CCBHCs, was guided in large part by an Environmental Scan prepared for SAMHSA in September 2014, which reviewed most of the existing laws, regulations and standards mentioned above (Moran, Daniels, Ghose et al. (2014)), as well as by Centers for Medicare & Medicaid Services (CMS) regulations governing participation of CMHCs in Medicare (42 CFR Part 485). The environmental scan revealed that:

- There is wide variation across States in the procedures and criteria for regulating CBHC operations and activities and in the scope and structure of State Medicaid Plans (including waivers, amendments, and demonstration grants) as they apply to and cover behavioral health services. For example, crisis mental health services and targeted case management, which are required by the PAM Act, are included in the majority of, if not all, State Medicaid Plans, while other services, such as 24/7 mobile crisis teams, are not part of most State Medicaid Plans.
- Accrediting organizations have behavioral health criteria for CBHCs and many CBHCs work with accrediting organizations to meet those criteria. Some States waive some portion of their own review if the CBHC has met accrediting organization criteria (CBHCs receive “deemed status”).
- There is guidance to be gained from criteria applicable to FQHCs, which are sometimes similar to those specified in the statute applicable to CCBHCs.
- Unlike FQHCs, which must report data annually to the U.S. Health Resources & Services Administration (HRSA) using the Uniform Data Set (UDS), there is no common data set currently for use by CBHCs. States have certain behavioral health reporting requirements through SAMHSA block grant programs and other granting opportunities, but these may not be sufficient to address requirements in the statute establishing CCBHCs (Moran, Daniels, Ghose et al. (2014)).

In addition to the results of the environmental scan, the CMS Medicare regulations applicable to CMHCs offer additional guidance in some of these areas, most particularly staffing, coordination of services, person-centered and family-centered treatment, and quality assessment and performance improvement (42 CFR Part 485).

Definitions

Important terms used in these criteria are defined below.

Behavioral health: Behavioral health is a general term that encompasses the promotion of emotional health; the prevention of mental health and substance use disorders; and treatment and services for substance use disorders, mental illness, and or mental disorders.

Care coordination: The Agency for Healthcare Research and Quality (2014) defines care coordination as "deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." As used here, the term applies to activities by the CCBHCs that have the purpose of coordinating and managing the care and services furnished to each consumer as required by the PAM Act (including both behavioral and physical health care), whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers outside the CCBHC.

Case management: Case management is an aspect of "coordination of patient care, including diagnosis, treatment and ongoing patient management (e.g., arranging referrals, follow-up of test results, patient education, patient reminders) by an individual other than the primary care clinician" (Tricco, Antony, Ivers et al. (2014); Shojania, Ranji, McDonald et al. (2006)).

CCBHC or Clinic: CCBHC and Clinic are used interchangeably to refer to Certified Community Behavioral Health Clinics as certified by States in accordance with these criteria.

Consumer, also known as clients, service recipients and patients: Within this document, "consumer" refers to clients, service recipients and patients, all used interchangeably to refer to persons of all ages who receive health care services, including mental health and substance use services, at CCBHCs. Use of the term "patient" is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word "consumer" is used to be consistent with current HHS language preference.

Cultural and linguistic competence: Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse patients (Office of Minority Health (2014)).

Family-centered: The Health Resources and Services Administration defines family-centered care as "an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes that families are the ultimate decisionmakers for their children, with children gradually taking on more and more of this decision-making themselves. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family's relationship with the child's health care providers and recognize the family's customs and values" (Health Resources and Services Administration (2004)). More recently, this concept has been broadened to explicitly recognize that family centered services are both developmentally appropriate and youth guided (American Academy of Child & Adolescent Psychiatry (2009)). Family-centered care is *family-driven* and *youth-driven*.

Formal arrangements: As used in these criteria, formal arrangements take the form of a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements as may be appropriate given the CCBHC's care coordination or service partner.

LEP: LEP means Limited English Proficiency. LEP includes individuals who do not speak English as their primary language and/or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

Partnership: As used in these criteria, a partnership is an arrangement that the CCBHC has with another entity, evidenced by a letter of support from the partnering entity.

Person-centered care: Person-centered care is care that is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act (ACA), as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services, June 6, 2014). That guidance defines "person-centered planning" as a process directed by the person with service needs that identifies recovery goals, objectives and strategies. If the consumer wishes, this process may include a

representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others the person wishes to include. Person-centered planning involves the consumer to the maximum extent possible. Person-centered planning also involves self-direction, which means that the consumer has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers (Department of Health & Human Services, June 6, 2014).

Recovery: Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The 10 guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect (Substance Abuse and Mental Health Services Administration (2012)).

Targeted case management: Targeted case management is case management, as defined above, directed at specific groups, which may vary by State. Examples of groups that might be targeted for case management could include individuals with developmental or intellectual disabilities, children and adults with serious emotional disturbance or serious mental illness or substance use disorders, pregnant women who meet risk criteria, individuals with HIV, and such other groups as a State might identify as in need of targeted case management.

Trauma informed: A trauma-informed approach to care is one that: "*realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization.*" The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration (2014)).

Structure of the criteria

Each Program Requirement corresponds to a section of the PAM Act, with the statutory authority for each Program Requirement identified at the beginning of the pertinent section. Within the tables laying out criteria we include: 1) the applicable statutory language and 2) the related criteria.

Within the criteria, the reader will see certain criteria labeled as "**Additional Recommendations**." These are optional criteria that States may elect to require and to which CBHCs may elect to adhere, even if the State does not require it for certification. They are standards that will enhance the quality of services provided by CCBHCs, and which will be considered but not required as part of the selection process. SAMHSA realizes that, in certain States, adherence to these **Additional Recommendations** may be difficult. One example would be the use of telehealth to provide distant services not available at the CCBHC. Some States do not include telehealth or limit telehealth within their State Medicaid Plans. Therefore, requiring use of telehealth for all States is not possible.

Also within the criteria, the reader will see "**Notes**." In some instances, **Notes** are clarifications of a criterion. In other instances, **Notes** provide States an opportunity to explain why a criterion may not be satisfied. One example would be the requirement that CCBHCs utilize credentialed peer specialists. Some States may not yet credential peer providers and there is a **Note** recognizing that as a legitimate reason not to satisfy the criterion.

Vision guiding certification

The CCBHCs represent an opportunity for States to improve the behavioral health of their citizens by providing community-based mental health and substance use disorder treatment, to advance to the next stage of integration with physical health care, to assimilate and utilize evidence-based practices on a more consistent basis, and to provide improved access to high quality care. Although the CCBHC demonstration program and PPS are designed to work within the scope of State Medicaid Plans and to apply specifically to individuals who are Medicaid enrollees, the statute also requires that the CCBHCs not refuse service to any person based either on ability to pay or residence. This requirement, together with the fact that improving access to and the quality of health care for the Medicaid population may also positively affect the health of others, means that the CCBHC demonstration program may have long-lasting and beneficial effects beyond the realm of Medicaid enrollees. Further, while the statute is clear that the CCBHCs are to provide services to all who seek help, it is anticipated that the CCBHCs will prove particularly valuable for individuals with serious mental illness (SMI), children and adolescents with serious emotional disturbance (SED) and those with co-occurring mental health, substance use and/or physical health disorders. Those who are most in need of coordinated, integrated quality care will receive it from CCBHCs. Finally, the statute directs that the care provided be "patient-centered." It is expected that CCBHCs will offer care that is person-centered and family-centered in accordance with the requirements of section 2402(a) of the ACA, trauma-informed, and recovery oriented and that the integration of physical and behavioral health care will serve the "whole person" rather than simply one disconnected aspect of the individual. The criteria are infused with these expectations and States are encouraged to certify clinics that provide care consistent with these principles.

Program Requirement 1: STAFFING

Within the bounds of State licensure and certification regulations, CCBHC staffing should include Medicaid-enrolled providers who adequately address the needs of the consumer population served. Credentialed, certified, and licensed professionals with adequate training in person-centered, family-centered, trauma-informed, culturally competent and recovery oriented care will help assure that this objective is attained. Care that meets these standards will further help the CCBHCs achieve integrated and high quality care.

Authority: Section 223 (a(2(A))) of the PAM Act

The statute requires the published criteria to include criteria with respect to the following:

"Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population."

Criteria 1.A: General Staffing Requirements	
1.a.1	The CCBHC has a documented assessment of the needs of its target consumer population, including cultural, linguistic and treatment needs. The needs assessment should be performed prior to implementation of the CCBHC to inform staffing and services and should include both consumer and family/caregiver input. The needs assessment should be updated regularly, no less than every three years.
1.a.2	The staff (both clinical and non-clinical) is appropriate for serving the consumer population in terms of size and composition and providing the types of services that the CCBHC proposes to offer. **Note:** See also Program Requirement 4.j relating to required staffing of services for veterans.
1.a.3	The staff (both clinical and non-clinical) has diverse disciplinary backgrounds appropriate for serving the consumer population.

Criteria 1.A: General Staffing Requirements	
1.a.4	The CCBHC maintains a fully staffed management team as appropriate for the size and needs of the clinic, including but not limited to a Chief Executive Officer or Executive Director/Project Director, and a psychiatrist as Medical Director. The psychiatrist will assure that the medical component of care and the integration of behavioral health and primary care is facilitated. **Note:** If a CCBHC is unable to employ a psychiatrist as Medical Director due to a documented workforce shortage in its vicinity, psychiatric consultation will be obtained on the medical component of care and the integration of behavioral health and primary care.
1.a.5	The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.

Criteria 1.B: Licensure and Credentialing of Providers	
1.b.1	All CCBHC providers who furnish services directly, under contract, or as part of other arrangements with the CCBHC, are legally authorized (licensed, certified or registered) in accordance with Federal, State and local laws, and act only within the scope of their State licenses, certifications, or registrations. All personnel qualifications are kept current at all times.

Criteria 1.B: Licensure and Credentialing of Providers	
1.b.2	At a minimum, the CCBHC staff is composed, either as CCBHC employed staff or through formal arrangements, of the following disciplines: (1) psychiatry (board certified or eligible for board certification in psychiatry and capable of prescribing medications for the treatment of opioid and alcohol use disorders); (2) psychiatric nursing; (3) credentialed substance abuse specialist(s); (4) at least one licensed mental health professional trained and credentialed to perform psychological testing; (5) staff trained to provide case management; (6) certified peer specialist(s)/recovery coaches; (7) staff trained to provide family support; and (8) some combination of the following: (a) licensed independent clinical social workers, (b) licensed mental health counselors, (c) licensed psychologists, (d) licensed marriage and family therapists, and (e) licensed occupational therapists. Providers serving CCBHC consumers include individuals with expertise in addressing trauma and the needs of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). **Note:** If a CCBHC is unable to employ or contract with a psychiatrist for face to face treatment due to a documented workforce shortage in its vicinity, psychiatric services may be provided through telehealth consultation.
1.b.3	**Additional Recommendation:** Child and adolescent psychiatrists are available for specialized care and/or consultation. Due to shortages of providers in certain regions, this may require use of telehealth or staffing of other licensed providers with experience and/or training in treating children and adolescents, such as child psychiatric nurse practitioners.

Criteria 1.C: Cultural Competence and Other Training	
1.c.1	The CCBHC provides or arranges training on person-centered and family-centered care and cultural competence in working with culturally or otherwise diverse consumer populations for all staff and contract providers who have contact with consumers or their families. Training for personnel addresses differences within the organization's service population with regard to culture, age, gender, gender identity, sexual orientation, military culture, spiritual beliefs and socioeconomic status as those may be factors in service delivery. Such training occurs at orientation and at least annually thereafter. **Note:** See also Program Requirement 4.j relating to cultural competency requirements in services for veterans.
1.c.2	CCBHC staff is trained to provide risk assessment and suicide prevention, trauma-informed care, recovery-oriented care (incorporating the concept of shared decision-making), and health integration. Such training occurs at orientation and at least annually thereafter.
1.c.3	The CCBHC assess the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs where indicated. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided during the previous 12 months.
1.c.4	The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed.
1.c.5	Individuals providing annual staff training are qualified as evidenced by education, training and experience.

Criteria 1.D: Linguistic Competence	
1.d.1	If the CCBHC serves individuals with limited English proficiency (LEP) or with disabilities, the CCBHC takes reasonable steps to provide meaningful access to their services.

Criteria 1.D: Linguistic Competence	
1.d.2	Interpretation/translation service(s) are provided that are appropriate and timely for the size/needs of the LEP CCBHC consumer population (e.g., bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.
1.d.3	Auxiliary aids and services are readily available, ADA compliant, and responsive to the needs of consumers with disabilities (e.g., sign language interpreters, TTY lines).
1.d.4	Documents or messages vital to a consumer's ability to access CCBHC services (for example, registration forms, sliding scale fee discount schedule, after hours coverage, signage) are provided to consumers in the appropriate languages, literacy levels, and/or alternative formats (for consumers with disabilities) and in a timely manner at intake.
1.d.5	The CCBHC's policies have explicit provisions for assuring that all employees, affiliated providers and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider, including but not limited to the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other Federal and State laws.

Program Requirement 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES

CCBHC should offer services in a manner that is accessible and available to individuals in their community. Significant aspects of accessibility and availability include the need for access at times and places convenient to those served, prompt intake and engagement in services, access regardless of ability to pay and place of residence, access to adequate crisis services, and consumer choice in treatment planning and services. Since the emergency department (ED) is often a source of crisis care, CCBHCs must have clearly established relationships with local EDs to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care. Use of peer, recovery and clinical supports in the community and increased access through the use of telehealth and mobile in-home supports also will further the statutory objective of availability and access to services.

Authority: Section 223 (a(2(B))) of the PAM Act

The statute requires the published criteria to include criteria with respect to the following:

"Availability and accessibility of services, including: crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence."

Criteria 2.A: General Requirements of Access and Availability	
2.a.1	The CCBHC provides a safe, functional, sanitary and welcoming environment for consumers and staff that is conducive to the provision of services identified in Program Requirement 4.
2.a.2	The CCBHC provides services during times that assure accessibility and meet the needs of the consumer population to be served.

2.a.3	The CCBHC provides services at locations including mobile in-home supports that assure accessibility and meet the needs of the consumer population to be served.
2.a.4	The CCBHC ensures there are outreach and engagement activities to assist consumers and families to access services. Through outreach and engagement, unserved and/or underserved consumers and families are educated about behavioral health and linked to needed services.
2.a.5	Services are subject to all state standards including the provision for voluntary and court ordered services.

Criteria 2.B: Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers	
2.b.1	All new consumers requesting or being referred for behavioral health services must receive an initial evaluation within one business day and a more comprehensive person-centered and family-centered diagnostic and treatment planning evaluation within 15 calendar days, unless State or Federal time requirements are more stringent.
2.b.2	The initial evaluation will include, at a minimum, (1) the primary diagnosis and other diagnoses, (2) the source of referral, (3) the reason for seeking care, as stated by the consumer or other individuals who are significantly involved, (4) identification of the consumer's immediate clinical care needs related to the psychiatric diagnosis, (5) a list of current prescriptions and over-the-counter medications, as well as other substances that the consumer may be taking, (6) an assessment of whether the consumer is a risk to his or herself or to others, including suicide risk factors, (7) an initial medical screening, including family medical history, as provided for in Program Requirement 4, and (8) a determination of whether the person presently is or ever has been a member of the United States Armed Services.

Criteria 2.B: Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers	
2.b.3	A comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is completed by licensed mental health professionals who, in conjunction with the consumer, are members of the treatment team, performing within their State's scope of practice. The comprehensive evaluation is completed no later than 15 calendar days after intake at the CCBHC, unless State or Federal time requirements are more stringent. The comprehensive assessment includes, at a minimum: (1) reasons for seeking services at the CCBHC, (2) a psychiatric evaluation that includes psychiatric history, medical history and severity of symptoms, (3) information concerning previous and current mental status, including but not limited to previous therapeutic interventions and hospitalizations, (4) information regarding the onset of symptoms of the illness and circumstances leading to the consumer's presentation to the CCBHC, (5) an assessment for alcohol and other substance use disorders, (6) a description of attitudes and behaviors, including cultural and environmental factors, that may affect the consumer's treatment plan, (7) an assessment of intellectual functioning, memory functioning, and orientation, (8) complications and risk factors that may affect care planning, (9) functional status, including the consumer's ability to understand and participate in his or her own care, and the consumer's strengths and goals, (10) factors affecting consumer safety or the safety of others, including behavioral and physical factors as well as suicide risk factors, (11) a drug profile that includes all of the consumer's prescriptions and over-the-counter medications, herbal remedies, and other alternative treatments or substances that could affect drug therapy, as well as information on drug allergies, (12) the need for referrals and further evaluation by appropriate health care professionals, including the consumer's primary care provider (if any), when warranted, (13) factors to be considered in discharge planning, (14) identification of the consumer's current social and health care support systems, and (15) for pediatric consumers, the CCBHC must assess the social service needs of the consumer and make referrals to social services and child welfare agencies as appropriate.

Criteria 2.B: Requirements for Timely Access to Services and Initial and Comprehensive Evaluation for New Consumers	
2.b.4	The comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is updated by the treatment team, in agreement with and endorsed by the consumer and in consultation with the primary care provider (if any), when changes in the consumer's status, responses to treatment, or goal achievement have occurred. The assessment must be updated no less frequently than every 30 days.
2.b.5	Waiting times for all services for established CCBHC consumers are less than 15 calendar days from the desired date of appointment, unless State or Federal time requirements are more stringent.

Criteria 2.C: 24/7 Access to Crisis Management Services	
2.c.1	Professional coverage is available through clearly defined arrangements, for behavioral health emergencies during hours when the clinic is closed. The CCBHC also provides crisis management services that are available and accessible 24 hours a day and delivered within three hours from the time services are requested with a target (average) response time of 1 hour. Details of required crisis management services are provided in Program Requirement 4.
2.c.2	The methods for providing crisis management services are clearly described in the policies and procedures of the CCBHC.
2.c.3	Individuals who are served by the CCBHC are educated about crisis management services and Advanced Directives and how to access those services at the time of intake. This includes individuals with limited English proficiency (LEP) or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with Program Requirement 1.
2.c.4	CCBHCs maintain a working relationship with the community hospital Emergency Departments (ED). Protocols are established for CCBHC staff to address the needs of individuals in crisis who come to the EDs.

Criteria 2.C: 24/7 Access to Crisis Management Services	
2.c.5	Protocols are in place to reduce delays for initiating services during and following a crisis. This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment. CCBHC consumers who are discharged from the hospital, ED or a residential crisis setting, are contacted by CCBHC staff within 24 hours.
2.c.6	**Additional Recommendation:** In rural areas, or in locations with few providers, CCBHC considers the provision of transportation or transportation vouchers for consumers or CCBHC staff. The CCBHC also considers the use of mobile in-home or telehealth services to assure that CCBHC consumers have access to all required services.

Criteria 2.D: No Refusal of Services due to Inability to Pay	
2.d.1	The CCBHC assures that: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, due to an individual's ability to pay for such services, and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).
2.d.2	The CCBHC has a published sliding fee discount schedule(s) that includes all services that the CCBHC proposes to offer. Such fee schedule will be included on the CCBHC website and posted in the CCBHC waiting room. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have Limited English Proficiency (LEP) or disabilities.
2.d.3	The sliding fee discount schedule(s), to the extent relevant, conforms to State statutory or administrative requirements or to Federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable State or Federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.

Criteria 2.D: No Refusal of Services due to Inability to Pay	
2.d.4	The CCBHC has written policies and procedures that describe eligibility for and implementation of the sliding fee discount program that is applied equally to all individuals seeking services.

Criteria 2.E: Provision of Services Regardless of Residence	
2.e.1	The CCBHC assures that no individual is denied behavioral health care services, including but not limited to crisis management services, due to place of residence or homelessness or who is otherwise without a permanent address.
2.e.2	CCBHCs have protocols and/or agreements with other localities for addressing the needs of consumers who do not live close to a CCBHC. CCBHCs are responsible to provide, at a minimum, crisis response, evaluation and stabilization services and should address the management of the individual's on-going treatment needs within the above protocols. Options include the use of telehealth and transfer to a more accessible service organization.

Program Requirement 3: CARE COORDINATION

The Agency for Healthcare Research and Quality (2014) defines care coordination as involving "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." CCBHCs should be guided by this definition as they provide integrated and coordinated care to address all aspects of a person's health. Person-centered and family-centered care is care that is aligned with the requirements of Section 2402(a) of the ACA, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services, June 6, 2014). Person-centered and family-centered care considers the consumer's choice in care services provided, as well as the physical, behavioral health, and social service needs of each individual as these factors influence the well-being of the whole person. Whether services are provided directly by the CCBHC staff or through partnership with other medical and/or service providers in the community, adequate communication and collaboration between providers is essential to best address the consumer's needs and preferences.

Authority: Section 223 (a(2(C))) of the PAM Act

The statute requires the published criteria to include criteria with respect to the following:

"Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics."

Criteria 3.A: General Requirements of Care Coordination	
3.a.1	Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with State regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health needs, as well as social services, educational systems, and employment opportunities necessary to facilitate wellness and recovery. **Note:** See also Program Requirement 4.j relating to care coordination requirements for veterans.
3.a.2	The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other Federal and State privacy laws and to assure that consumers' preferences and those of families of children and youth for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care.
3.a.3	Consistent with requirements of privacy and confidentiality, the CCBHC assists consumers and the families of children and youth referred to external providers or resources to obtain an appointment, tracks that the appointment was kept and reviews and tracks the care, treatment and services provided.
3.a.4	As an on-going part of care coordination, the CCBHC maintains a dialogue with the consumer about the consumer's preferences and needs for care and, to the extent possible and in accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer.
3.a.5	Appropriate care coordination assures that all those who prescribe medication for CCBHC consumers are aware of any medications prescribed by other providers.

Criteria 3.B: Care Coordination and Other Health Information Systems	
3.b.1	The CCBHC establishes and/or maintains an electronic health records system.

Criteria 3.B: Care Coordination and Other Health Information Systems	
3.b.2	The CCBHC establishes and maintains consumer registries to measure the quality of health care provided.
3.b.3	The CCBHC establishes and/or maintains a care coordination system that supports and assures adequate communication, care planning, and coordination between all CCBHC staff, provider partners, and community services.
3.b.4	**Additional Recommendation:** The CCBHC may elect to establish and/or maintain an electronic care coordination system that supports and assures adequate communication, care planning, and coordination between all CCBHC staff, provider partners, and community services.

Criteria 3.C: Care Coordination Partners	
3.c.1	The CCBHC has a formal arrangement with Federally-Qualified Health Centers (FQHC) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent that the services are not provided directly through the CCBHC. To the extent that consumers are connected with other primary care providers, the CCBHC has established protocols to assure adequate care coordination. **Note**: If an agreement cannot be established (e.g., provider does not exist in their service area), justification is provided and contingency plans are established with other providers that can offer similar services (e.g., primary care, preventive services, other medical care services).

Criteria 3.C: Care Coordination Partners	
3.c.2	The CCBHC has a formal arrangement with programs that can provide inpatient psychiatric treatment, with substance use detoxification, post-detoxification step-down services, and with residential programs to provide those services to CCBHC consumers. The CCHBC is able to track when consumers are admitted to facilities providing the above services, as well as when they are discharged. The CCBHC has established protocols and procedures for transitioning individuals from emergency departments, inpatient psychiatric, detoxification, and residential settings to a safe community setting. This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety and provision for peer services that is consistent with the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)) and 42 CFR Part 2.
3.c.3	The CCBHC has either a partnership or formal arrangement with other community or regional services, supports, and providers including (but not limited to): • Educational systems; • Employment services system; • Child welfare agencies; • Juvenile and criminal justice agencies and facilities; • Indian Health Service youth regional treatment centers; • State licensed and nationally accredited child placing agencies for therapeutic foster care service; and • Other social and human services (e.g., aging centers, homeless shelters, housing). **Note**: For these services, a letter of support from the partnering entity may suffice. If an agreement (formal or otherwise) cannot be established, justification and contingency plans are provided (e.g., provider does not exist in their service area).
3.c.4	The CCBHC has a formal arrangement with the Department of Veterans Affairs' medical centers, independent clinics, drop-in centers, and other facilities of the Department.

Criteria 3.C: Care Coordination Partners	
3.c.5	The CCBHC has a formal arrangement with inpatient acute-care hospitals, including emergency departments, and hospital outpatient clinics to address the needs of CCBHC consumers. The arrangement is such that the CCBHC can track when their consumers are admitted to facilities providing the above services, as well as when they are discharged. The arrangement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.
3.c.6	The CCBHC's formal arrangements take the form of a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements as may be appropriate given the care coordination partner.
3.c.7	The entities with which the CCBHC coordinates care, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.

Criteria 3.D: Treatment Team, Treatment Planning and Care Coordination Activities	
3.d.1	The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer wishes and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of Section 2402(a) of the ACA.
3.d.2	The CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the physical, medical, behavioral, psychosocial, emotional and therapeutic needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian/Alaska Native (AI/AN). **Note:** See also Program Requirement 4.j relating to required treatment planning services for veterans.

Criteria 3.D: Treatment Team, Treatment Planning and Care Coordination Activities	
3.d.3	As part of care coordination, the CCBHC ensures that care and services provided by the CCBHC and its partnering providers are provided in accordance with the active treatment plan. **Note:** See also Program Requirement 4 related to scope of service and person-centered and family-centered treatment planning.

Program Requirement 4: SCOPE OF SERVICES

Person-centered care is care that is aligned with the requirements of Section 2402(a) of the ACA, and is care in which the consumer is actively involved and has the ability to self-direct services received, having maximum choice and control over his or her services, "including the amount, duration, and scope of services and supports as well as choice of provider(s)" (Department of Health & Human Services, June 6, 2014). CCBHCs are required by the PAM Act to provide directly, or through partnerships, a broad array of services to meet the needs of the population served and to do so in a person-centered and family-centered manner. While the statute lists minimum requirements that will need to be met, States also will have flexibility to shape the scope of services within the required areas to be aligned with their State Medicaid Plans and other State regulations. The intention and expectation is that States will establish scope of service requirements that encourage CCBHCs to expand the availability of high-quality integrated person-centered and family-centered care as envisioned by the statute, and to assure the continual integration of new evidence-based practices.

Authority: Section 223 (a(2(D))) of the PAM Act

The statute requires the published criteria to include criteria with respect to the following:

"Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration."

Criteria 4.A: Requirement of Person-Centered and Family-Centered Care	
4.a.1	The CCBHC ensures that all CCBHC services, including those through formal arrangement with other providers, are provided in a manner aligned with the requirements of Section 2402(a) of the ACA, reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and assuring both consumer involvement and self-direction of services received. Services to children and youth are family-centered, youth guided and developmentally appropriate. **Note:** See also Program Requirement 3 regarding coordination of services and treatment planning. See also Program Requirement 4.j relating specifically to requirements for services for veterans.
4.a.2	Person-centered and family-centered care includes care that recognizes the particular cultural and other needs of the individual. This includes for consumers who are AI/AN, access to traditional approaches or medicines as part of CCBHC services. These services may be provided either directly or by formal arrangement with tribal providers.

	Criteria 4.B: Crisis Behavioral Health Services
4.b.1	The CCBHC directly provides crisis behavioral health services (including services for suicide crisis response) including: • 24-hour mobile crisis teams, • Emergency crisis intervention services, and • Crisis stabilization. **Note:** The PAM Act requires provision of these three crisis behavioral health services. As part of the certification process, the States will clearly define each term as they are using it. As a general matter, 24 hour mobile crisis teams are understood to provide rapid crisis response to consumers and families at a range of community settings, and to provide assessment, brief intervention and linkage/referral and collaboration with other crisis and behavioral health services, such as crisis hotlines which may perform triage and dispatch functions. Emergency crisis intervention services are understood to mean services such as psychiatric emergency and crisis teams and ambulatory detox. In addition, emergency crisis teams may integrate crisis hotlines and peer crisis services into their responses. Crisis stabilization services are understood to provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization such as 23 hour crisis stabilization beds, crisis stabilization units, and crisis respite and crisis residential services. Crisis stabilization services may follow emergency room visits and psychiatric hospitalizations. **Note:** See also Program Requirement 2 related to crisis management services and Program Requirement 3 regarding coordination of services and treatment planning. **Note:** The Prospective Payment System (PPS) is not authorized to reimburse for non-ambulatory care, which may have implications for respite and crisis residential care and certainly precludes coverage of inpatient crisis care.

Criteria 4.B: Crisis Behavioral Health Services	
4.b.2	Even though the CCBHC provides these crisis services itself, the CCBHC enters into a formal arrangement with local emergency departments, urgent care centers, inpatient facilities, and medical detoxification inpatient facilities that permit the CCBHC to coordinate any care that may be provided at those locations and to facilitate follow-up if a CCBHC consumer is seen by one of these facilities.
4.b.3	CCBHCs are able to address directly, or through formal arrangement, crises related to substance abuse and intoxication. Resources include use of ambulatory substance use and detoxification teams, as well as employing peers on crisis teams.

Criteria 4.C: Screening, Assessment and Diagnosis	
4.c.1	The CCBHC directly provides screening, assessment, and diagnosis, including risk assessment, for behavioral health conditions. Although the CCBHC provides screening, assessment and diagnosis as a routine part of their services, in the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment or diagnosis (e.g., neurological testing, developmental testing and assessment, eating disorders, cardiac conditions), the CCBHC makes them available through formal arrangement with other providers or, where necessary and appropriate, through use of telehealth services. **Note:** See also Program Requirement 3 regarding coordination of services and treatment planning.
4.c.2	Screening, assessment and diagnosis are conducted in a time frame that responds to the individual consumer's needs and are of sufficient scope to assess the need for all services required to be provided by CCBHCs.

Criteria 4.C: Screening, Assessment and Diagnosis	
4.c.3	Documented screening and assessment includes, at a minimum: (1) presenting problems and urgent needs; (2) diagnostic assessment, including for mental health (including but not limited to depression screening) and substance use disorders (with the latter to include tobacco, alcohol and other drugs); (3) imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate threats); (4) psychosocial history (including trauma history); (5) emotional-behavioral functioning; (7) basic competency/cognitive impairment screening; (8) vocational and educational status; (9) family/caregiver and social support assessment; (10) legal issues; (11) insurance status, (12) basic physical assessment comprised of provider observation, measurement of BMI and blood pressure, consumer self-report, family medical history, and assessment of need for a physical exam (with referral and follow-up); (13) where appropriate, pregnancy status; and (14) assessment of need for other specific services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services, LEP or linguistic/translation services). **Note:** See section 4.f, below, related to requirements for primary care screening, monitoring and care.
4.c.4	The CCBHC uses standardized and validated screening and assessment tools and, where appropriate, brief motivational interviewing techniques.
4.c.5	The CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities (e.g., hearing disability, cognitive limitations), when appropriate.
4.c.6	If screening identifies unsafe substance use including problematic alcohol use, a brief intervention is conducted by the CCBHC and the consumer is referred for or provided a full assessment and treatment, if applicable.

Criteria 4.D: Person-Centered and Family-Centered Treatment Planning	
4.d.1	The CCBHC directly provides person-centered and family-centered treatment planning or similar processes, including but not limited to risk assessment and crisis planning. Person-centered and family-centered treatment planning satisfies the requirements of sections 4.d.2 – 4.d.9 below and is aligned with the requirements of Section 2402(a) of the ACA, including consumer involvement and self-direction. **Note:** See also Program Requirement 3 related to coordination of care and treatment planning.
4.d.2	An individualized plan that integrates prevention, medical and behavioral health needs and service delivery is developed by the CCBHC in collaboration with and endorsed by the consumer or family/caregiver of youth and children and coordinated with staff or programs necessary to carry out the plan, **Note:** States may wish to utilize additional resources related to person-centered treatment planning found in the CMS Medicaid Home and Community Based Services regulations at 42 C.F.R. Part 441, Subpart M, or in the CMS Medicare Conditions of Participation for Community Mental Health Centers regulations at 42 C.F.R. Part 485.
4.d.3	The CCBHC uses consumer assessments to inform the treatment plan and services provided.
4.d.4	Treatment planning includes needs, strengths, abilities, preferences and goals, expressed in a manner that captures the consumer's words or ideas and, when appropriate, those of the consumer's family/caregiver.
4.d.5	The treatment plan is comprehensive, addressing all services required, with provision for monitoring of progress towards goals.
4.d.6	Where appropriate, consultation is sought during treatment planning about special emphasis problems, including for treatment planning purposes (e.g., trauma, eating disorders).
4.d.7	The treatment plan documents the consumer's advance wishes related to crisis management.

Criteria 4.D: Person-Centered and Family-Centered Treatment Planning	
4.d.8	Person-centered and family-centered treatment planning includes, among other things, provision for, as necessary, prevention; community inclusion and support; involvement of family/caregiver and other supports; recovery planning; safety planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, accommodations to assure cultural and linguistically competent services).
4.d.9	**Additional Recommendation:** States should assess the best options for person-centered and family-centered treatment planning based on the CCBHC consumer population served and the individual State Medicaid Plan. Options could include: use of telehealth to facilitate services and use of Wellness Recovery Action Plans (WRAPs).

Criteria 4.E: Outpatient Mental Health and Substance Use Services	
4.e.1	The CCBHC directly provides outpatient mental health and substance use services that are evidence-based or best practices, such as the practices identified on SAMHSA's National Registry of Evidence-based Programs and Practices. Although the CCBHC provides these as a routine part of their services, in the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental health and substance use treatment (e.g., treatment of sexual trauma, eating disorders), the CCBHC makes them available through formal arrangement with other providers or, where necessary and appropriate, through use of telehealth services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate to the consumers served in the CCBHC area. **Note:** See also Program Requirement 3 regarding coordination of services and treatment planning.

Criteria 4.E: Outpatient Mental Health and Substance Use Services	
4.e.2	The mental health and substance use services that CCBHCs must directly provide to CCBHC consumers include: (1) evidence-based individual, group and family therapies including Cognitive Behavioral individual and group therapies (CBT), Dialectical Behavior Therapy (DBT), first episode early intervention for psychosis, Multisystemic Therapy, specialty clinical interventions to treat mental health and substance use disorders experienced by youth including youth in Therapeutic Foster Care, and Motivational Interviewing; (2) evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injection and oral), acamprosate, naloxone), prescription long-acting injectable medications for both mental health and substance use disorders, and smoking cessation medications); (3) evidence-based intensive services such as intensive outpatient substance abuse services and intensive psychiatric outpatient services; and (4) prevention services.
4.e.3	In addition to the requirements in criteria 4.e.2, the following services must be available when needed: follow-up care after hospitalization, emergency department use or crisis services use; evidence-based suicide safety and treatment services; smoking cessation therapy; evidence-based co-occurring mental and substance use treatment; evidence-based trauma informed treatments; evidence based treatment for youth and children; evidence-based treatment for older adults (including geriatric consultation); evidence-based treatment for co-occurring developmental disabilities and mental health disorders; and neurological consultation.
4.e.4	When treating children and adolescents, CCHBCs provide evidenced-based services that are developmentally appropriate, youth guided, and family/caregiver driven with respect to children and adolescents. They are delivered by staff with specific training in treating children and adolescents.
4.e.5	Children and adolescents are treated using a family/caregiver-driven and youth guided and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance abuse, psychosocial, and environmental issues.

Criteria 4.F: Outpatient Clinic Primary Care Screening and Monitoring	
4.f.1	The CCBHC directly collects physical health information on each consumer through consumer (or caregiver) self-report, provider observation, and measurement of BMI and blood pressure, at intake and at least annually thereafter. The CCBHC also directly provides or makes available through formal arrangement, more in-depth screening and monitoring of key health indicators and health risks. The CCBHC refers each consumer for primary care services, assures that key aspects of primary care are provided (including but not limited to laboratory and other screening and management required as part of Program Requirement 5 (e.g., diabetes screening and management, blood pressure screening and management, weight measurement), and follows-up to assure that appropriate primary care is provided. For children, the CCBHC ensures that children receive age appropriate screening and preventive interventions including but not limited to assessment of learning disabilities, family/caregiver functioning, and trauma screening. Prevention services are a key part of both the primary care screening directly provided and made available through formal arrangement by the CCBHC. **Note:** See also Program Requirement 3 regarding coordination of services and treatment planning.

Criteria 4.G: Case Management Services	
4.g.1	The CCBHC directly provides high quality case management including: referral to indicated community services; follow-up supports to persons deemed at higher risk of suicide, particularly during times of transitions such as from an emergency department or psychiatric hospitalization; Assertive community treatment (ACT); targeted case management; and community wrap-around services for youth and children.
4.g.2	**Additional Recommendation:** Additional case management services may include: Forensic Assertive Community Treatment (F-ACT); services in a variety of formats including face-to-face and via technology-based platforms (e.g., telephone, online chat, video-conferencing and mobile health (mHealth) applications such as text messaging).

Criteria 4.H: Psychiatric Rehabilitation Services	
4.h.1	The CCBHC directly provides, or makes available through formal arrangement, evidence-based psychiatric rehabilitation services, including medication education; self-management; training in personal care skills; individual and family/caregiver psycho-education; community integration services; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education. **Note:** See also Program Requirement 3 regarding coordination of services and treatment planning.
4.h.2	The CCBHC directly provides, or makes available through formal arrangement, psychiatric rehabilitation services that include supported housing; supported employment; and supported education.

Criteria 4.I: Peer Supports, Peer Counseling and Family/Caregiver Supports	
4.i.1	The CCBHC directly provides peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Family/caregiver support services include: family/caregiver psycho-education, parent training and family-to-family/caregiver support services. **Note:** See also Program Requirement 1.b.2 requiring peer staff and Program Requirement 3 regarding coordination of services and treatment planning.
4.i.2	**Additional Recommendation:** The CCBHC may also provide directly or through formal arrangement: peer-run drop-in centers; peer crisis support services; peer bridge services to assist individuals transitioning between residential or inpatient settings to the community; peer trauma support; peer support for older adults or youth; and peer recovery services.

Criteria 4.J: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.j.1	The CCBHC directly provides, or makes available through formal arrangement, intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. **Note:** See also Program Requirement 3 regarding coordination of services and treatment planning.
4.j.2	All individuals inquiring about services are asked if they have ever served in the US military. Persons affirming current military service will be offered assistance in coordinating services with TRICARE, and persons affirming former military service (hereafter referred to as veteran) will be offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA, including clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). **Note:** See also Program Requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.
4.j.3	In keeping with the general criteria governing CCBHCs, CCBHCs ensure that there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both and for integration or coordination between care for mental health conditions and other components of health care for all veterans.

Criteria 4.J: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.j.4	Every veteran seen in behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one mental health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the medical record. The Principal Behavioral Health Provider is identified on a consumer tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures that: (1) Regular contact is maintained with the veteran as clinically indicated as long as ongoing care is required. (2) A psychiatrist reviews and reconciles each veteran's psychiatric medications on a regular basis. (3) Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity). (4) Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. (5) The treatment plan is revised, when necessary.

Criteria 4.J: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.j.4 (continued)	(6) The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as patients with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future mental health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2). (7) The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects that the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure that the veteran's decision making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

Criteria 4.J: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.j.5	In keeping with the general criteria governing CCBHCs, behavioral health services are recovery-oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery that updated the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The 10 guiding principles of recovery are: • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect (Substance Abuse and Mental Health Services Administration (2012)). Additionally, as implemented in VHA recovery, the recovery principles also include: • Privacy • Security • Honor Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adhere to guidelines promulgated by the VHA.

Criteria 4.J: Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans	
4.j.6	In keeping with the general criteria governing CCBHCs, all behavioral health care is provided with cultural competence. (1) Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country. (2) All staff receives cultural competence training addressing ethnic and minority issues, and issues of sexual orientation and gender identity.
4.j.7	In keeping with the general criteria governing CCBHCs, there is a mental health treatment plan for all veterans receiving behavioral health services. (1) The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. (2) The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself. (3) As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness. (4) The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments. (5) The treatment plan is developed with input from the veteran, and when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

Program Requirement 5: QUALITY AND OTHER REPORTING

Data collection, use and reporting are vital for assessment and improvement of program quality. As a condition of participation in the demonstration program, the statute requires States to collect and report on encounter, clinical outcomes, and quality improvement data. The statute also requires annual reporting by the States and that will entail collection of data that can be used to assess the impact of the demonstration program on: (a) access to community-based behavioral health services (including through comparison to other areas of the State not targeted by the demonstration); (b) quality and scope of services provided by CCBHCs that can be compared to non-CCBHC providers; and (c) Federal and State costs of a full range of mental health services (including inpatient, emergency, and ambulatory services). The criteria related to this Program Requirement are designed to elicit the data needed to assure improved access to care, high quality services and appropriate State reporting.

Authority: Section 223 (a(2(E))) of the PAM Act

The statute requires the published criteria to include criteria with respect to the following:

"Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires."

Criteria 5.A: Data Collection, Reporting and Tracking	
5.a.1	The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to measures that capture the following: (1) consumer demographics; (2) staffing; (3) use of services (i.e., encounter data); (4) access to services; (5) care coordination; (6) other processes of care; (7) consumer outcomes; and (8) screening and prevention.
5.a.2	State must have the capacity to provide CCHBC-level Medicaid claims data to the evaluators of this demonstration. If requested, CCBHCs will participate in discussions with the national evaluation team.

Criteria 5.B: Quality Improvement (QI) Plan	
5.b.1	The CCBHC develops, implements, and maintains an effective, CCBHC-wide data-driven quality improvement (QI) plan for clinical services and clinical management. The QI projects are clearly defined, implemented, and evaluated annually. The number and scope of distinct QI projects conducted annually are based on the needs of the CCBHC's population and reflect the scope, complexity and past performance of the CCBHC's services and operations. The CCBHC-wide QI plan addresses priorities for improved quality of care and client safety, and requires that all improvement activities be evaluated for effectiveness. The QI plan focuses on indicators related to improved behavioral and physical health outcomes, and takes actions to demonstrate improvement in CCBHC performance. The CCBHC documents each QI project implemented, the reasons for the projects, and the measurable progress achieved by the projects. One or more individuals are designated as responsible for operating the QI program.

Criteria 5.C: Quality Measurement	
5.c.1	Quality measures are collected and submitted by the CCBHC to the State and by the State to HHS on a quarterly basis, including but not limited to data in the following domains: (1) consumer demographics; (2) staffing; (3) use of services (i.e., encounter data); (4) access to services; (5) care coordination; (6) other processes of care; (7) consumer outcomes; and (8) screening and prevention. In addition to the measures listed in Appendix A that are reported by CCBHCs to States and by States to HHS and the national evaluation contractor quarterly, States shall also report additional measures to HHS and the national evaluation contractor quarterly. The data sources for these additional measures are claims from CCBHCs and non-CCBHC providers, and information collected from control clinics, and will include, among other things, cost data.

Criteria 5.C: Quality Measurement	
5.c.2	**Patient demographics.** Each CCBHC determines the characteristics of the Medicaid consumers served, including counts of the number of Medicaid consumers served by demographic status (age, gender, housing). CCBHCs are encouraged, but not required, to collect information on other sociodemographic characteristics such as income, housing status, employment status, race, ethnicity, sexual orientation and gender identity, primary language, and veteran and military duty status; clinical characteristics such as primary diagnosis, co-morbid mental health and substance use disorders; information on consumers served that are not enrolled in Medicaid; treatment rates relative to population needs.
5.c.3	**Staffing**. CCBHCs measure the number of FTEs by clinician type; staff to consumer ratios; percentage of staff receiving cultural competency training; percentage of staff receiving suicide prevention and assessment training; and percentage of staff receiving training in the provision of trauma-informed care.
5.c.4	**Quantity and scope of services used (encounter data).** CCBHCs collect annual counts of visits by service type among Medicaid beneficiaries; the number of Medicaid consumers served by the CCBHC who are hospitalized for mental health, substance abuse or other conditions; the number of Medicaid consumers served by the CCBHC who utilize the emergency department for mental health, substance abuse or other conditions.
5.c.5	**Access to services**. Measures of access to care include measures of wait time for a routine CCHBC visits; and compliance with interpretation requirements.
5.c.6	**Care coordination.** Care coordination measures include measures of the percentage of CCBHC Medicaid consumers receiving post-discharge follow-up after mental health or substance use disorder hospital admissions or emergency department visits and information on initiation and engagement in substance use disorder treatment.
5.c.7	**Appropriateness of services provided**. CCBHCs measure whether CCBHCs are documenting current medications in each consumer's medical record. CCHBCs are encouraged, but not required, to report on the provision of evidence based practices.

Criteria 5.C: Quality Measurement	
5.c.8	**Consumer outcomes.** A patient and family/caregiver experience of care survey is required.
5.c.9	**Screening and Prevention.** CCBHCs measure the extent to which they are appropriately providing suicide screening, tobacco screening and cessation treatment, alcohol screening and brief intervention, trauma screening, and intimate partner violence screening; body mass index screening, hypertension screening, diabetes screening, cardiovascular screening. They must also measure whether CCBHC consumers have appropriate connections to a primary care provider.

Program Requirement 6: ORGANIZATIONAL AUTHORITY, GOVERANCE AND ACCREDITATION

It is envisioned that the organizations that meet the CCBHC standards will be able to provide comprehensive and high quality services in a manner that reflects evidence based and best practices in the field. Combined with the other program requirements of Section 223, the criteria within this section are meant to bolster States' ability to identify and support organizations with demonstrated capacity and capability to meet the CCBHC criteria.

Authority: Section 223 (a(2(F))) of the PAM Act

The statute requires the published criteria to include criteria with respect to the following:

"Criteria that a clinic be a nonprofit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)."

Criteria 6.A: Organizational Authority	
6.a.1	The CCBHC maintains documentation establishing that the CCBHC conforms to at least one of the following criteria: • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code; • Is part of a local government behavioral health authority; • Is operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.); • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).
6.a.2	**Additional Recommendation:** To the extent that CCBHCs are not operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal or urban Indian organization, CCBHCs are strongly encouraged to reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to AI/AN consumers and to inform the provision of services to those consumers. To the extent that the CCBHC and such entities jointly provide services, the CCBHC and those partner entities shall, as a whole, satisfy the requirements of these criteria.

Criteria 6.B: Governance	
6.b.1	CCBHC governing board maintains appropriate authority to oversee the clinical and financial operations of the clinic. As a group, the CCBHC governing board members reasonably represent those served at the CCBHC in terms of geographic areas, race, ethnicity, sex, gender identity, disability, age, and sexual orientation.

Criteria 6.B: Governance	
6.b.2	At least 51% of the CCBHC governing board is composed of members who represent a mixture of adult consumers with serious mental illness who are receiving (or have received) behavioral health services and families of children with serious emotional disturbance who are receiving (or have received) behavioral health services.
6.b.3	An independent financial audit is performed in accordance with Federal audit requirements, and, where indicated, a corrective action plan is submitted that addresses all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.

Criteria 6.C: Accreditation	
6.c.1	CCBHCs will follow any applicable State accreditation and/or licensing requirements.
6.c.2	**Additional Recommendation:** States are encouraged to require accreditation of the CCBHCs by an appropriate nationally-recognized organization (e.g., Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), Accreditation Association for Ambulatory Health Care (AAAHC)).
6.c.3	**Additional Recommendation:** Organizations that meet CCBHC standards should have the ability to provide both mental health and substance use services as well as address the needs of individuals with co-occurring mental and substance use conditions. In some States this could be established by requiring joint State licensure as outpatient mental health clinics and outpatient substance abuse clinics.

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Appendix A: Certified Community Behavioral Health Clinics Quality Measures

Required Measures

Table 1. Consumer Characteristics Measures

Potential Source of Measure	Measure Description	NBHQF Recommended[2]
Encounter data	Number of Medicaid Patients served by age, gender, and housing status/living situation	No

Table 2. Staffing Measures

Potential Source of Measure	Measure Description	NBHQF Recommended
Personnel records	FTEs by clinician type	No
Personnel records and organizational data	Staff to client ratios	No
Personnel records	Percentage of staff receiving cultural competency training	No
Personnel records	Percentage of staff receiving suicide prevention and assessment training	No
Personnel records	Percentage of staff receiving training in the provision of trauma-informed care	No

[2] NBHQF is National Behavioral Health Quality Framework.

Potential Source of Measure	Measure Description	NBHQF Recommended
Personnel records	Percentage of staff receiving recovery model training	No

Table 3. Quantity and Scope of Services Used (Encounter Data)

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure[3] # (if endorsed)	NBHQF Recommended
Chart Review/Encounter data	CCBHC visits by service type among Medicaid beneficiaries	Uniform Data System (UDS) (FQHC Data System)	No	No

[3] NQF is National Quality Forum.

Table 4. Access Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Administrative data	Number/Percent of clients requesting services who were determined to need routine care; Number/percent of clients with appointment provided within 15 calendar days; Number/percent of clients who were offered appointment within 15 calendar days but declined appointment; Number/percent of clients who had an appointment within 15 calendar days but did not "show"	Modified from North Carolina Department of Mental Health, Developmental Disabilities, and Substance Abuse Services; Kansas Medicaid.	No	No
Administrative data	Compliance with interpretation requirements	No	No	No

Table 5. Care Coordination Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Encounter data	Timely Transmission of Transition Record	Medicaid Core Set (adult)	0648 0649	Yes

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Chart Review/Encounter data	Initiation and engagement of alcohol and other drug dependence treatment	PQRS, MU, Dual Eligibles Core Quality Measures-Capitated Demonstrations; Dual Eligibles Core Quality Measures-Managed Fee For Service Demonstrations; Medicare Core Set Adults); HEDIS, Medicaid claims/encounter; Medicare Cost set (adult)	0004	No

Table 6. Process of Care Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Chart Review/Administrative claims	Documentation of current Medications in the Medical Records	2014 Adult core Medicaid Measure CMS68v1	0419	No

Table 7. Outcome Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Survey of consumers	Patient experience of care survey	SAMHSA Uniform Reporting System (URS)	No	Yes
Survey of families	Family experience of care survey	SAMHSA Uniform Reporting System (URS)	No	Yes
Chart Review/Encounter data	Number of Suicides by Patients Engaged in Behavioral Health (CCBHC) Treatment	No	No	No
Chart Review/Encounter data	Number of Suicide Attempts by Patients Engaged in Behavioral Health (CCBHC) Treatment	No	No	No

Table 8. Screening and Prevention Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended Measure
Medicaid claims, encounter data, chart review	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment	PQRS	1365	Yes
Medicaid claims, encounter data, chart review	Adult major depressive disorder (MDD): Suicide risk assessment	PQRS, MU	0104	Yes
Medicaid claims, encounter data, chart review	Medical Assistance with Smoking and Tobacco Use Cessation	MU1, PQRI, ACO Medicaid Core set (adult); PQRS; Medicare Shared Savings	0027	Yes
Medicaid claims, encounter data, chart review	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	PQRS	2152	Yes
Medicaid claims	Screening and Appropriate Brief Intervention or Treatment for Trauma	MU2	No	Yes
Medicaid claims, encounter data, chart review	Screening for Intimate Partner Violence	No	No	Yes
Medicaid claims	Percentage of clients seen by a primary care physician or pediatrician or obstetrician/gynecologist in the past year	No	No	Yes
Medicaid claims, encounter data, chart review	Body Mass Index in adults > 18 years of age	Medicaid Core (adult)	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended Measure
Medicaid claims, encounter data, chart review	Controlling High Blood Pressure	Medicaid Core (adult)	0018	No
Medicaid claims, encounter data, chart review	Comprehensive Diabetes Care: LDL-C Screening	Medicaid Core (adult)	0063	No
Medicaid claims, encounter data, chart review	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Medicaid Core (adult)	0057	No
Medicaid claims, encounter data, chart review	Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	No	1927	Yes
Medicaid claims, encounter data, chart review	Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia	No	1933	Yes

Optional Measures

Table 1b. Consumer Demographics and Selected Characteristics: Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs
Medicaid enrollment records; SAMHSA National Survey on Drug Use and Health	Measure of service use relative to potential need such as relative to prevalence rates as indicated on the National Survey of Drug Use and Health or relative to the number of Medicaid enrollees in the state or CCHBC catchment area.	No
Encounter data	Other sociodemographic measures: geographic region within state; ethnicity, race, primary language, income, employment, veteran and active duty military	Uniform Data System (UDS) (FQHC Data System); SAMHSA Uniform Reporting System (URS)
Encounter data	Data on other non-Medicaid persons served by CCBHC	SAMHSA Uniform Reporting System (URS)
Chart review/Medicaid Claims	Data on clinical conditions such as primary diagnosis reported; percent with of adults with co-occurring substance abuse and mental illness; percent of adults serious mental illness; percent of children with serious emotional disturbance	SAMHSA Uniform Reporting System (URS)

Table 2b. Staffing: Optional Measures

Potential Source of Measure	Measure Description	NBHQF Recommended
Personnel records	Number of child-serving professionals trained in providing trauma-informed services, as captured during the time period of the demonstration (GPRA 3.2.24)	Additional measures for consideration
Personnel records	Total number of individuals trained in youth suicide prevention, as captured during the time period of the demonstration (GPRA 2.3.59)	Additional measures for consideration
Personnel records	Tenure by clinician type, as captured during the time period of the demonstration (Uniform Data System (UDS) (FQHC Data System))	No

Table 3b. Quantity and Scope of Services Used (Encounter Data): Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Medications\ Management	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Dual Diagnosis Treatment	SAMHSA Uniform Reporting System (URS)	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Illness Self Management	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Supported Employment	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Supported Housing	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Family Psycho-Education	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Adult Evidence-Based Practice Assertive Community Treatment	SAMHSA Uniform Reporting System (URS)	No	No

Potential Source of Measure	**Measure Description**	**Use of Measure in Public Programs**	**NQF measure # (if endorsed)**	**NBHQF Recommended**
Encounter data; chart review	Number of clients receiving Child/Adolescent Evidence-Based Practice Services Multi Systemic Therapy	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Child/Adolescent Evidence-Based Practice Services Therapeutic Foster Care	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients receiving Child/Adolescent Evidence-Based Practice Services Functional Family Therapy	SAMHSA Uniform Reporting System (URS)	No	No
Encounter data; chart review	Number of clients using Certified Peer Specialist Services	No	No	No
Encounter data; chart review	Number of clients using Family Support Services	No	No	No
Encounter data; chart review	Number of clients receiving intensive mental health care for members of the armed forces and veterans	No	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Encounter data; chart review	Number of clients using 24/7 Mobile Crisis Services	No	No	No
Encounter data; chart review	Documented housing assistance/stabilization if warranted	No	No	Additional measures for consideration
Encounter data; chart review	Documented employment/ educational assistance/support provided if warranted	No	No	Additional measures for consideration

Table 4b. Access Measures: Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Encounter data; chart review	Adults with SMI receiving appropriate treatment without having to be involuntarily hospitalized or committed	No	No	Additional measures for consideration
Consumer survey	Clients reporting positively about access by Age, Gender, Race/Ethnicity and Housing Status	SAMHSA Uniform Reporting System (URS)	No	No
Encounter and administrative data	Assessment at intake of need for interpretive/translation services	No	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Consumer/family survey	Family Members Reporting High Cultural Sensitivity of Staff by Age, Gender, and Race/Ethnicity	SAMHSA Uniform Reporting System (URS)	No	No
Encounter and administrative data	Methodologies in place to ensure eligible clients are enrolled in health insurance	No	No	Yes

Table 5b. Care Coordination Measures: Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Medicaid claims/encounter data	Follow-Up Referral and Adequate Connection to Care After Emergency Department Visit for Substance Abuse, Mental Illness, Suicide Attempt	No	No	Yes
Medicaid claims/encounter data	Percentage of detox to outpatient admission; % of inpatient detox episodes that have 7 day follow-up; % of outpatient detox episodes that have 7 day follow-up	No	No	Additional measures for consideration
Medicaid claims/encounter data	Follow-up care for children prescribed ADHD medication	PQRS, Medicaid Core set (children); CHIPRAQR; MU	0108	Yes
Administrative claims; encounter data	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	ACO	0646	Yes

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
CCBHC self-report	Use of electronic health records	MU	No	No
Consumer survey	Percentage of patients who report effective care coordination between their behavioral health treatment provider and their primary care provider	No	No	Additional measures for consideration

Table 6b. Process of Care Measures: Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Medicaid claims/encounter data	Adults with SMI receiving illness self-management	SAMHSA Uniform Reporting System (URS)	No	Additional measures for consideration
Medicaid claims/encounter data	Use and Adherence to Antipsychotics Among Members with Schizophrenia	No	0105	Additional measures for consideration
Medicaid claims/encounter data	Antidepressant Medication Management	Dual Eligibles Core Quality Measures-Capitiated Demonstrations; Medicaid Core set (adults); MU; Medicare Part C Plan Rating; PQRS	No	Additional measures for consideration
Medicaid claims/encounter data	Antipsychotic Use in Children Under 5 Years Old	No	2337	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Medicaid claims/encounter data	Patients on Multiple Antipsychotic Medications	No	No	Yes
Medicaid claims/encounter data	Lithium, Annual Lithium Test in Ambulatory Setting	No	No	Additional measures for consideration
Medicaid claims/encounter data/ chart review	Adults with SMI receiving medication management	No	No	Additional measures for consideration
Patient/family survey	Systematically assessing client and/or family perceptions of shared decision-making	No	No	Additional measures for consideration
Chart review	Percentage of patients for which treatment goals were identified in health record	No	No	Additional measures for consideration
Chart review	For child services: documentation of family engagement in treatment planning	No	No	Additional measures for consideration

Table 7b. Outcome Measures: Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Chart review	Readmissions to any psychiatric hospital: 30 days	SAMHSA Uniform Reporting System (URS); NOMS	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Chart review	State hospital readmission rates	SAMHSA Uniform Reporting System (URS); NOMS	No	No
Chart review	Depression Remission at 12 months	PQRS, MU	0710	No
Chart review	Depression response at six months, Progress towards remission	No	1884	No
Chart review	Depression response at twelve months, progress towards remission	No	1885	No
Chart review	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	No	1879	No
Medicaid claims/encounter data	Adherence to Mood Stabilizers for Individuals with Bipolar Disorder	No	1880	No
Chart review	Patients Reporting Abstinence After Treatment for Addiction	No	No	Yes
Chart review	Global Assessment of Functioning (GAF) or Children's Global Assessment Scale (CGAS)	SAMHSA Uniform Reporting System (URS)	No	No
Chart review	Outcomes Reflecting Recovery	SAMHSA Uniform Reporting System (URS)	No	Yes
Patient experience survey	Client reporting about quality and appropriateness by age, gender and race/ethnicity	SAMHSA Uniform Reporting System (URS)	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended
Patient experience survey	Clients Reporting Positively About Outcomes by Age, Gender, and Race/Ethnicity	SAMHSA Uniform Reporting System (URS)	No	No
Patient experience survey	Clients Reporting Positively about General Satisfaction with Services by Age, Gender, and Race/Ethnicity	SAMHSA Uniform Reporting System (URS)	No	No
Chart review/Patient report	Arrest rates by age	SAMHSA Uniform Reporting System (URS)	No	No
Chart review	Change in number of arrests in past 30 days from date of first service to date of last service	No	No	Additional measures for consideration
Medicaid claims/encounter	Number of clients experiencing a drug overdose	No	No	**No**

Table 8b. Screening and Prevention: Optional Measures

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended Measure
Chart review	Trimester of Entry Into Prenatal Care	Uniform Data System (UDS) (FQHC Data System) and PQRS	No	No

Potential Source of Measure	Measure Description	Use of Measure in Public Programs	NQF measure # (if endorsed)	NBHQF Recommended Measure
Chart review	Childhood Immunization Status	Uniform Data System (UDS) (FQHC Data System), MU	No	No
Self-report/administrative data	Percentage of providers distributing (either orally or written) prevention materials	No	No	Additional measures for consideration